State of California
Health and Welfare Agency

Department of Health Services

Chapter 3

Attachment A

CALIFORNIA CHILDREN SERVICES

ORTHOTIC AND/OR PROSTHETIC FACILITY APPLICATION

A CCS approved Orthotic and/or Prosthetic Facility must: (1) Be accredited by the American Board for Certification in Orthotics and Prosthetics (ABC) or the Board for Orthotist/Prosthetist Certification (BOC) **OR** (2) Meet all criteria in Section B of this application.

In addition:
Have a **minimum** of one CCS paneled practitioner on staff of the specialty in which the facility is applying (Orthotics, Prosthetics or both).

(Please type or print in ink

APPLICATION IS BEING MADE FOR:

Orthotic facility ☐ Prosthetic facility ☐ Orthotic and Prosthetic facility ☐

NAME OF FACILITY _____ ABC ACCREDITATION NUMBER _____ (Attach copy of Certificate

ADDRESS _____

CITY _____ ZIP CODE _____ COUNTY _____

TELEPHONE: AREA CODE _____ NUMBER _____ EXTENSION _____

NAME OF PERSON IN CHARGE AT THIS ADDRESS _____

LAST FIRE DEPARTMENT INSPECTION WAS MADE _____
MONTH YEAR

WRITTEN REFERENCE IS BEING SUBMITTED BY DOCTOR(S) _____

_____

DOES THE FACILITY HAVE ANY BRANCH OFFICES? YES ☐ NO ☐

IF YES, LIST NAMES AND ADDRESS FOR EACH LOCATION. LIST P&O PROCEDURES CARRIED OUT IN BRANCH OFFICE (FULL SERVICE; PARTIAL SERVICE). USE SEPARATE SHEET IF NECESSARY.

_____

_____

_____

_____

SECTION A (Facility Personnel)
List names and certificate numbers (Use separate sheet if necessary.)

1. Certified Practitioners — Name _____ Certificate No. _____

2. Registered Assistants — Name _____ Certificate No _____

3. Registered Technicians — Name _____ Certificate No _____

SECTION B (Physical Plant)

1. The facility is located in a:

Store Building ____ Office Building ____ Hospital ____ Other _____

EXPLAIN ALL "NO" ANSWERS

2. Is the exterior and interior of the facility neat and clean? YES ____ NO ____

3. Does the facility have adequate parking space for handicapped persons? YES ____ NO ____

4. Is there easy access to the facility for wheelchair and other disabled patients (i.e., no steps; solid handrails for ramps; doors wide enough, etc.)? YES ____ NO ____

5. Does the facility provide a separate waiting area adequate for the patient load? YES ____ NO ____

6. Are the reception and patient management areas separated from the laboratory area by a floor to ceiling partition? YES ____ NO ____

7. How many rest rooms are located in the facility?

8. Can wheelchair patients use the rest rooms? YES ____ NO ____

9. Are grab bars provided for safety in the rest rooms? YES ____ NO ____

10. How many fitting rooms are there in the facility?

11. Is there a sturdy set of parallel bars at least eight feet long? YES ☐ NO ☐

12. a. Is there a full length mirror installed at one end of the parallel bars? YES ☐ NO ☐

    b. Are the parallel bars easily accessible from at least one of the fitting rooms for wheelchair patients? YES ☐ NO ☐

13. Can wheelchair patients navigate through: a. halls? YES ☐ NO ☐
    b. doorways? YES ☐ NO ☐

14. Does a certified orthotist or prosthetist do the actual measuring, casting, and fitting of patients? YES ☐ NO ☐

15. Is the laboratory adequately equipped to perform routine services for orthotic and/or prosthetic patients? YES ☐ NO ☐

16. Is there an adequate inventory of components and repair parts and finished goods to provide routine P and/or O services for the extent and type of services the facility is providing? YES ☐ NO ☐

17. Are adequate fire precautions taken in the laboratory? YES ☐ NO ☐

18. Are adequate provisions made for the collection of dust and fumes in the laboratory? YES ☐ NO ☐

19. Is the responsible individual for the facility aware of the Occupational Safety and Health Act (OSHA)? YES ☐ NO ☐

20. Do you think adequate precautions have been taken to ensure the safety of the employees and patients? YES ☐ NO ☐

    Please explain

I certify that the information I have provided above is true and correct to the best of my knowledge.

I understand that P & O devices and services require prior authorization.

I agree to:

a. Bill insurance first (within two [2] months of the month of service[s]).
b. Bill CCS within two (2) months of the month of service, insurance payment or insurance rejection. (Bill CCS within twelve [12] months of date of service if insurance fails to respond.)

c. Accept payment in accordance with State regulations as payment in full; not bill families in whole or part for any CCS covered benefit; not question families regarding their ability to pay for CCS covered benefits.

d. Accept Medi-Cal patients authorized by CCS

e. Serve CCS patients regardless of race, color, religion, national origin or ancestry.

Signature | Title | Date

PLEASE RETURN TO:

California Children's Services
Provider Services Unit
MS 8105
P.O. Box 997413
Sacramento, CA 95899-7413